NORTHSIDE HOSPITAL

Atlanta • Forsyth • Cherokee

Health Risk Assessment (must be reviewed by physician, signed & dated)
Annual Wellness Visit ___Initial ___ Subsequent

Patient's name: _____
Date of Birth: _____
Medicare B eligibility date: _____
Today's date: _____

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health and health care possible.

1. What is your age? _ 65-69 _ 70-79 _ 80 or older

2. Are you a female or a male? _ Male _ Female

3. During the past four weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

_ Not at all
_ Slightly
_ Moderately
_ Quite a bit
_ Extremely

4. During the past four weeks, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?

_ Not at all
_ Slightly
_ Moderately
_ Quite a bit
_ Extremely

5. During the past four weeks, how much bodily pain have you generally had?

_ No pain
_ Very mild pain
_ Mild pain
_ Moderate pain
_ Severe pain

6. During the past four weeks, was someone available to help you if you needed and wanted help? (For example, if you felt very nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)

_ Yes, as much as I wanted
_ Yes, quite a bit
_ Yes, some
_ Yes, a little
_ No, not at all

7. During the past four weeks, what was the hardest physical activity you could do for at least two minutes?

_ Very heavy
_ Heavy
_ Moderate
_ Light
_ Very light

8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car?)

_ Yes _ No

9. Can you go shopping for groceries or clothes without someone's help?

_ Yes _ No

10. Can you prepare your own meals? _ Yes _ No

11. Can you do your housework without help? _ Yes _ No

12. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?

_ Yes _ No

13. Can you handle your own money without help? _ Yes _ No

14. During the past four weeks, how would you rate your health in general?

_ Excellent
_ Very good
_ Good
_ Fair
_ Poor

15. How have things been going for you during the past four weeks?

_ Very well; could hardly be better
_ Pretty well
_ Good and bad parts about equal
_ Pretty bad
_ Very bad; could hardly be worse

16. Are you having difficulties driving your car?

_ Yes, often
_ Sometimes
_ No
_ Not applicable, I do not use a car

17. Do you al ways fasten your seat belt when you are in a car?

_ Yes, usually
_ Yes, sometimes
_ No

18. How often during the past four weeks have you been *bothered* by any of the following problems?

Please indicate with: Never, Seldom, Sometimes, Often or Always

Falling or dizzy when standing up_____
Sexual problems _____
Trouble eating well _____
Teeth or denture problems _____
Problems using the telephone _____
Tiredness or fatigue _____

19. Have you fallen two or more times in the past year? _ Yes _ No

20. Are you afraid of falling? _ Yes _ No

21. Are you a smoker?

_ No
_ Yes, and I might quit
_ Yes, but I'm not ready to quit

22. During the past four weeks, how many drinks of wine, beer, or other alcoholic beverages did you have?

_ 10 or more drinks per week
_ 6-9 drinks per week
_ 2-5 drinks per week
_ One drink or less per week
_ No alcohol at all

23. Do you exercise for about 20 minutes three or more days a week?

_ Yes, most of the time
_ Yes, some of the time
_ No, I usually do not exercise this much

24. Have you been given any information to help you with the following:

Hazards in your house that might hurt you? _ Yes _ No
Keeping track of your medications? _ Yes _ No

25. How often do you have trouble taking medicines the way you have been told to take them?

_ I do not have to take medicine
_ I always take them as prescribed
_ Sometimes I take them as prescribed
_ I seldom take them as prescribed

26. How confident are you that you can control and manage most of your health problems?

_ Very confident
_ Somewhat confident
_ Not very confident
_ I do not have any health problems

27. What is your race? (Check all that apply.)

_ White
_ Black or African American
_ Asian
_ Native Hawaiian or Other Pacific Islander
_ American Indian or Alaskan Native
_ Hispanic or Latino origin or descent
_ Other

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.

Physician's signature: _____ **Date:** _____

NORTHSIDE HOSPITAL
Atlanta • Forsyth • Cherokee

MEDICARE PREVENTIVE PHYSICAL EXAM
ANNUAL WELLNESS VISIT ___ Initial AWV

Patient's name: _____ **Date of Birth:** _____
Medicare B enrollment date: _____ *
*enrollment date MUST be more than 12 months
Today's date: _____
Health Risk Assessment has been reviewed by physician, signed & dated: initial _____

MEDICAL/SOCIAL HISTORY

Past personal illnesses or injuries:

Injury/Illness/Surgery	Date	Hospitalized? (Indicate Yes or No)

Medications, supplements and vitamins:

Drug allergies/other allergies:

Social history notes (including diet, physical activities, alcohol use, drug use and tobacco use):

Family history of medical events/diseases (indicate Yes if family member has a positive history):

	Mother	Father	Brother	Sister	Son	Daughter
Deceased						
Hypertension						
Stroke						
Diabetes						
Kidney disease						
Heart disease						
Cancer						

Other physicians and providers/suppliers of care (include provider name, specialty & type of care)

DEPRESSION SCREEN*

1. Over the past 2 weeks, have you felt down, depressed or hopeless? _ Yes _ No
2. Over the past 2 weeks, have you felt little interest/pleasure in doing things? _ Yes _ No

FUNCTIONAL ABILITY/SAFETY SCREEN*

1. Was the patient's timed Up & Go test unsteady or long than 30 seconds? _ Yes _ No
2. Do you need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money? _ Yes _ No
3. Does your home have rugs in the hallway, lack grab bars in the bathroom, lack handrails on the stairs or have poor lighting? _ Yes _ No
4. Have you noticed any hearing difficulties? _ Yes _ No

*A "yes" answer to any of the questions regarding depression or function/safety should trigger further evaluation, screenings or referrals. (Use additional screening questionnaires)

PHYSICAL EXAMINATION

Height: _____ Weight: _____ Blood Pressure: _____ BMI: _____
Visual Acuity: Left _____ R _____

EVALUATION OF COGNITIVE FUNCTION

Mood/Affect: _____
Appearance: _____
Family member/Caregiver input: _____

EVALUATIONS/REFERRALS BASED ON HISTORY, EXAM AND SCREENING:
Provider must also complete Risk Factors/Referrals/Interventions

Physicians signature: _____ **Date:** _____
Continue to next page-Counseling and Referrals AND Risk Factors/Referrals/Interventions

NORTHSIDE HOSPITAL
Atlanta • Forsyth • Cherokee

COUNSELING AND/OR REFERRAL OF PREVENTIVE SERVICES

Create two copies of this page: One for the chart and one to give to the patient.

Patient's name: _____ DOB: _____
Today's date: _____

Service	Recommendation
Vaccinations	**Date or N/A**
Influenza (every 12 months)	
Pneumococcal (once in a lifetime)	
Hepatitis B	
Labs	**Date or N/A**
PSA-males (every 12 months)	
Cardiovascular screening-Lipid panel (every 5 years)	
Diabetes screening-FBS or GTT *	
*2 screening tests per year if diagnosed with pre-diabetes; 1 test per year if never tested OR tested previously but not diagnosed with pre-diabetes	
Women's Services	**Date or N/A**
Mammography screening (age 40 & over-annually)	
Pap smear (every 24 months or yearly if high risk)	
Pelvic exam (every 24 months or yearly if high risk)	
Diagnostic Services	**Date or N/A**
Bone mass measurement-DEXA (every 24 months)	
Glaucoma screening by an Optometrist (annually)	
Digital Rectal Exam-males (annually)	
Colorectal cancer screening (age 50 & over)*	
*FOBT (every 12 months)	
*Flex Sig (every 4 years or 120 months after screening colonoscopy for non-high risk)	
*Colonoscopy screening (every 10 yrs or 24 months for high risk)	
*Barium enema-as an alternative to Flex Sig (every 48 months or 24 months high risk)	
Additional Recommendations	
Diabetes self-management training	
Medical nutrition therapy services	
Abdominal aortic aneurysm screening-MUST be referred through IPPE (once in a lifetime)	

Physician's signature: _____ **Date:** _____
For an all inclusive list see "Medicare Preventive Services Quick Reference"

NORTHSIDE HOSPITAL
Atlanta • Forsyth • Cherokee

Screening for Depression

Patient's name: _____ **DOB:** _____
Today's date: _____

Instructions: Choose the best answer for how you felt over the past 2 weeks.

1. Are you basically satisfied with your life? YES / NO

2. Have you dropped many of your activities and interests? YES / NO

3. Do you feel that your life is empty? YES / NO

4. Do you often get bored? YES / NO

5. Are you in good spirits most of the time? YES / NO

6. Are you afraid that something bad is going to happen to you? YES / NO

7. Do you feel happy most of the time? YES / NO

8. Do you often feel helpless? YES / NO

9. Do you prefer to stay at home, rather than going out and doing new things? YES / NO

10. Do you feel you have more problems with memory than most? YES / NO

__ Provider assessment: No further evaluation needed.

__ Referral: _____

Physician's signature: _____ Date: _____

NORTHSIDE HOSPITAL
Atlanta • Forsyth • Cherokee

Personal Risk Factors Fall Prevention Checklist

Patient's name: _____ **DOB:** _____
Today's date: _____

1. Have you fallen before or been injured because of a fall? YES/NO

2. Do you feel weaker than you used to or have less strength in your arms and legs? YES/NO

3. Have you stopped doing daily activities or avoided exercise because you're afraid of falling? YES/NO

4. Do you experience incontinence? YES/NO

5. Has your hand strength decreased? YES/NO

6. Has your eyesight diminished or do you have trouble seeing depth or seeing at night? YES/NO

7. Do you feel dizzy when you stand up? YES/NO

8. Have you experienced hearing loss? YES/NO

9. Do you have foot ulcers, bunions, hammertoes or callouses that hurt or cause you to adjust your steps? YES/NO

10. Do you feel unsteady on your feet or shuffle when you walk? YES/NO

__ Provider assessment: No further evaluation needed.

__ Referral: _____

Physician's signature: _____ Date: _____